TO THE HONORABLE SENATE:

The Committee on Health & Welfare to which was referred Senate Bill No. 243 entitled "An act relating to combating opioid abuse in Vermont" respectfully reports that it has considered the same and recommends that the bill be amended by striking out all after the enacting clause and inserting in lieu thereof the following:

* * * Vermont Prescription Monitoring System * * *

Sec. 1. 18 V.S.A. § 4289 is amended to read:

§ 4289. STANDARDS AND GUIDELINES FOR HEALTH CARE PROVIDERS AND DISPENSERS

(a) Each professional licensing authority for health care providers shall develop evidence-based standards to guide health care providers in the appropriate prescription of Schedules II, III, and IV controlled substances for treatment of acute pain, chronic pain and for other medical conditions to be determined by the licensing authority. The standards developed by the licensing authorities shall be consistent with rules adopted by the Department of Health. **The licensing authorities shall submit their standards to the Commissioner of Health for review to ensure consistency across health care providers.**

(b)(1) Each health care provider who prescribes any Schedule II, III, or IV controlled substances shall register with the VPMS by November 15, 2013.

(2) If the VPMS shows that a patient has filled a prescription for a controlled substance written by a health care provider who is not a registered user of VPMS, the Commissioner of Health shall notify the applicable licensing authority and the provider by mail of the provider's registration requirement pursuant to subdivision (1) of this subsection.

(3) The Commissioner of Health shall develop additional procedures to ensure that all health care providers who prescribe controlled substances are registered in compliance with subdivision (1) of this subsection.

(c) Each dispenser who dispenses any Schedule II, III, or IV controlled substances shall register with the VPMS and shall query the VPMS in accordance with rules adopted by the Commissioner of Health.

(d)(1) Health care providers shall query the VPMS with respect to an individual patient in the following circumstances:

(1) ~~at least annually for patients who are receiving ongoing treatment with an opioid Schedule II, III, or IV controlled substance~~ prior to writing a prescription for any opioid Schedule II, III, or IV controlled substance, except in the case of hospice or end-of-life care**, in the event of technical or logistical difficulties,** or pursuant to other exceptions adopted by the Commissioner by rule;

(2) when starting a patient on a Schedule II, III, or IV non-opioid controlled substance for nonpalliative long-term pain therapy of 90 days or more; and

(3) ~~the first time the provider prescribes an opioid Schedule II, III, or IV controlled substance written to treat chronic pain; and~~

~~(4)~~ prior to writing a replacement prescription for a Schedule II, III, or IV controlled substance pursuant to section 4290 of this title.

(e) The Commissioner of Health shall, after consultation with the Unified Pain Management System Advisory Council, adopt rules necessary to effect the purposes of this section. ~~The Commissioner and the Council shall consider additional circumstances under which health care providers should be required to query the VPMS, including whether health care providers should be required to query the VPMS when a patient requests renewal of a prescription for an opioid Schedule II, III, or IV controlled substance written to treat acute pain~~.

(f) Each professional licensing authority for dispensers shall adopt standards, consistent with rules adopted by the Department of Health under this section, regarding the frequency and circumstances under which its respective licensees shall:

(1) query the VPMS; and

(2) report to the VPMS, which shall be no less than once every ~~seven days~~ 24 hours.

(g) Each professional licensing authority for health care providers and dispensers shall consider the statutory requirements, rules, and standards adopted pursuant to this section in disciplinary proceedings when determining whether a licensee has complied with the applicable standard of care.

* * * Unused Prescription Drug Disposal Program * * *

Sec. 2. STATEWIDE UNUSED PRESCRIPTION DRUG DISPOSAL PROGRAM

Safe disposal of unused prescription drugs is an essential part of reducing prescription drug abuse and diversion in Vermont. The Commissioners of Health and of Public Safety shall implement one or more of the options described in the January 2014 statewide drug disposal program report, or develop and implement a new drug disposal model, to be fully operational statewide on or before January 1, 2017. On or before October 1, 2016, the Commissioners shall notify the House Committees on Health Care, on Human Services, and on Judiciary, the Senate Committees on Health and Welfare and on Judiciary, and the Health Reform Oversight Committee which model they will implement and their strategy for informing Vermont residents about the new statewide drug disposal program. **Add manufacturer fee, funding for information, education, public service announcements?**

* * * Expanding Access to Substance Abuse Treatment

with Buprenorphine * * *

Sec. 3. 18 V.S.A. chapter 93 is amended to read:

CHAPTER 93. TREATMENT OF OPIOID ADDICTION

Subchapter 1. Regional Opioid Addiction Treatment System

§ 4751. PURPOSE

It is the purpose of this ~~chapter~~ subchapter to authorize the ~~department of health~~ Department of Health to establish a regional system of opioid addiction treatment.

* * *

Subchapter 2. Opioid Addiction Treatment Care Coordination

§ 4771. CARE COORDINATION

(a) In addition to participation in the regional system of opioid addiction treatment established pursuant to subchapter 1 of this chapter, health care providers may coordinate patient care in order to provide to the maximum number of patients high quality opioid addiction treatment with buprenorphine or a drug containing buprenorphine.

(b) Care for patients with opioid addiction may be provided by a care coordination team comprising the patient's primary care provider, a qualified addiction medicine physician or nurse practitioner **or physician assistant?** as

described in subsection (c) of this section, and members of a medication-assisted treatment team affiliated with the Blueprint for Health.

(c)(1) A primary care provider participating in the care coordination team and prescribing buprenorphine or a drug containing buprenorphine pursuant to this section shall meet federal requirements for prescribing buprenorphine or a drug containing buprenorphine to treat opioid addiction and shall see the patient he or she is treating for opioid addiction for an office visit at least once every three months.

(2) A qualified addiction medicine physician participating in a care coordination team pursuant to this section shall be a physician who is board-certified in addiction medicine. The qualified physician shall see the patient for addiction-related treatment other than the prescription of buprenorphine or a drug containing buprenorphine and shall advise the patient's primary care physician.

(3)(A) A qualified addiction medicine nurse practitioner participating in a care coordination team pursuant to this section shall be an advanced practice registered nurse who is certified as a nurse practitioner and who satisfies one or more of the following conditions:

(i) has completed not fewer than 24 hours of classroom or interactive training in the treatment and management of opioid-dependent patients for substance use disorders provided by the American Society of

Addiction Medicine, the American Academy of Addiction Psychiatry, the American Medical Association, the American Osteopathic Association, the American Psychiatric Association, or any other organization that the Commissioner of Health deems appropriate; or

(ii) has such other training and experience as the Commissioner of Health determines will demonstrate the ability of the nurse practitioner to treat and manage opioid dependent patients.

(B) The qualified nurse practitioner shall see the patient for addiction-related treatment other than the prescription of buprenorphine or a drug containing buprenorphine and shall advise the patient's primary care physician.

(d) The primary care provider, qualified addiction medicine physician or nurse practitioner, and medication-assisted treatment team members shall coordinate the patient's care and shall communicate with one another as often as needed to ensure that the patient receives the highest quality of care.

(e) The Director of the Blueprint for Health shall consider increasing payments to primary care providers participating in the Blueprint who choose to engage in care coordination by prescribing buprenorphine or a drug containing buprenorphine for patients with opioid addiction pursuant to this section.

OR direct Dept of Health to study, report on ways to increase, incentivize, provide support to primary care providers?

Sec. 4. TELEMEDICINE FOR TREATMENT OF SUBSTANCE USE DISORDER; PILOT

(a) The Green Mountain Care Board and Department of Vermont Health Access shall develop a pilot program to enable a patient taking buprenorphine or a drug containing buprenorphine for a substance use disorder to receive treatment from an addiction medicine specialist delivered through telemedicine at a health care facility that is capable of providing a secure telemedicine connection and whose location is convenient to the patient. The Board and the Department shall ensure that both the specialist and the hosting facility ~~**receive appropriate compensation**~~ **are reimbursed** for services rendered.

(b)(1) Patients beginning treatment for a substance use disorder with buprenorphine or a drug containing buprenorphine shall not receive treatment through telemedicine. A patient may receive treatment through telemedicine only after a period of stabilization on the buprenorphine or drug containing buprenorphine, as measured by an addiction medicine specialist using an assessment tool approved by the Department of Health.

(2) Notwithstanding the provisions of subdivision (1) of this subsection, patients whose care has been transferred from a regional specialty addictions treatment center may begin receiving treatment

through telemedicine immediately upon the transfer of care to an office-based opioid treatment provider.

(c) On or before January 15, 2017 and annually thereafter, the Board and the Department shall provide a progress report on the pilot program to the House Committees on Health Care and on Human Services and the Senate Committee on Health and Welfare.

* * * Expanding Role of Pharmacies and Pharmacists * * *

Sec. 5. 26 V.S.A. § 2022 is amended to read:

§ 2022. DEFINITIONS

As used in this chapter:

* * *

(14)(A) "Practice of pharmacy" means:

(i) the interpretation and evaluation of prescription orders;

(ii) the compounding, dispensing, and labeling of drugs and legend devices (except labeling by a manufacturer, packer, or distributor of nonprescription drugs and commercially packaged legend drugs and legend devices);

(iii) the participation in drug selection and drug utilization reviews;

(iv) the proper and safe storage of drugs and legend devices and the maintenance of proper records therefor;

(v) the responsibility for advising, where necessary or where regulated, of therapeutic values, content, hazards, and use of drugs and legend devices; ~~and~~

(vi) the providing of patient care services **within the pharmacist's authorized scope of practice (VMS)**;

(vii) the optimizing of drug therapy through the practice of clinical pharmacy; and

(viii) the offering or performing of those acts, services, operations, or transactions necessary in the conduct, operation, management, and control of pharmacy.

(B) "Practice of clinical pharmacy" means:

(i) the health science discipline in which, in conjunction with the patient's other practitioners, a pharmacist provides patient care to optimize medication therapy and to promote disease prevention and the patient's health and wellness;

(ii) the provision of patient care services **within the pharmacist's authorized scope of practice (VMS)**, including medication therapy management, comprehensive medication review, and post-diagnostic disease state management services; and

(iii) the practice of pharmacy by a pharmacist pursuant to a **~~clinical pharmacy~~ collaborative practice** agreement.

(C) A rule shall not be adopted by the Board under this chapter that shall require the sale and distribution of nonprescription drugs by a licensed pharmacist or under the supervision of a licensed pharmacist or otherwise interfere with the sale and distribution of such medicines.

* * *

(19) "**~~Clinical pharmacy agreement~~ Collaborative practice agreement (VMS/VPA)**" means **~~an~~ a written (VMS)** agreement between a pharmacist and a health care **~~entity~~ facility** or **prescribing (VMS)** practitioner that permits the pharmacist to engage in the practice of clinical pharmacy for the benefit of the entity's or practitioner's patients.

Sec. 6. 26 V.S.A. § 2023 is added to read:

§ 2023. CLINICAL PHARMACY

In accordance with rules adopted by the Board, a pharmacist may engage in the practice of clinical pharmacy.

Sec. 7. 8 V.S.A. § 4089j is amended to read:

§ 4089j. RETAIL PHARMACIES; FILLING OF PRESCRIPTIONS

(a) ~~A health insurer and pharmacy benefit manager doing business in Vermont shall permit a retail pharmacist licensed under 26 V.S.A. chapter 36 to fill prescriptions in the same manner and at the same level of reimbursement as they are filled by mail order pharmacies with respect to the quantity of drugs or days' supply of drugs dispensed under each prescription.~~

~~(b)~~ As used in this section:

(1) "Health insurer" ~~is defined by~~ shall have the same meaning as in 18 V.S.A. § 9402 and shall also include Medicaid and any other public health care assistance program.

(2) "Pharmacy benefit manager" means an entity that performs pharmacy benefit management. "Pharmacy benefit management" means an arrangement for the procurement of prescription drugs at negotiated dispensing rates, the administration or management of prescription drug benefits provided by a health insurance plan for the benefit of beneficiaries, or any of the following services provided with regard to the administration of pharmacy benefits:

(A) mail service pharmacy;

(B) claims processing, retail network management, and payment of claims to pharmacies for prescription drugs dispensed to beneficiaries;

(C) clinical formulary development and management services;

(D) rebate contracting and administration;

(E) certain patient compliance, therapeutic intervention, and generic substitution programs; and

(F) disease management programs.

(3) "Health care provider" means a person, partnership, or corporation, other than a facility or institution, that is licensed, certified, or otherwise

authorized by law to provide professional health care service in this State to an individual during that individual's medical care, treatment, or confinement.

(b) A health insurer and pharmacy benefit manager doing business in Vermont shall permit a retail pharmacist licensed under 26 V.S.A. chapter 36 to fill prescriptions in the same manner and at the same level of reimbursement as they are filled by mail order pharmacies with respect to the quantity of drugs or days' supply of drugs dispensed under each prescription.

(c) ~~This section shall apply to Medicaid and any other public health care assistance program.~~ Notwithstanding any provision of a health insurance plan to the contrary, if a health insurance plan provides for payment or reimbursement that is within the lawful scope of practice of a pharmacist, the insurer may provide payment or reimbursement for the service when the service is provided by a pharmacist.

~~(d)(1) A health insurer and pharmacy benefit manager doing business in Vermont shall reimburse a licensed pharmacist or a pharmacy technician under the supervision of a licensed pharmacist for conducting pill counts, pursuant to an order from a health care provider, of opioid controlled substances prescribed by the health care provider to his or her patients. The health insurer or pharmacy benefit manager shall determine the reimbursement amount, which shall be at least $10.00 per pill count for each prescribed medication counted. The pharmacist or~~

~~**pharmacy technician shall promptly report the results of the pill count to the health care provider who ordered it.**~~

~~**(2) Nothing in this subsection shall be construed to require a licensed pharmacist or pharmacy technician to conduct a pill count.**~~

~~**Sec. 8. BOARD OF PHARMACY; RULEMAKING**~~

~~**The Board of Pharmacy, in consultation with the Department of Health, shall adopt rules or procedures, or both, as appropriate, to provide guidance to licensed pharmacists and pharmacy technicians conducting pill counts of controlled substances pursuant to 8 V.S.A. § 4089j(d). The Board's rules or procedures, or both, shall take effect on or before July 1, 2017.**~~

Sec. 8. ROLE OF PHARMACIES IN PREVENTING OPIOID ABUSE; REPORT

(a) The Department of Health, in consultation with the Board of Pharmacy, pharmacists, prescribing health care practitioners, health insurers, pharmacy benefit managers, and other interested stakeholders shall consider the role of pharmacies in preventing opioid misuse, abuse, and diversion. The Department's evaluation shall include a consideration of whether, under what circumstances, and in what amount pharmacists should be reimbursed for counting or otherwise evaluating the quantity of

pills, films, patches, and solutions of opioid controlled substances prescribed by a health care provider to his or her patients.

(b) On or before January 15, 2017, the Department shall report to the House Committees on Health Care and Human Services and the Senate Committee on Health and Welfare its findings and recommendations with respect to the appropriate role of pharmacies in preventing opioid misuse, abuse, and diversion.

* * * Continuing Medical Education * * *

Sec. 9. CONTINUING EDUCATION; PROFESSIONAL LICENSING BOARDS

(a) On or before December 15, 2016, the professional boards that license physicians, osteopathic physicians, dentists, pharmacists, advanced practice registered nurses, naturopathic physicians, and any other profession authorized to prescribe controlled substances shall amend their continuing education rules to require ~~at~~ **a total of** least two hours of continuing education for each licensing period on the topic**s** of the abuse and diversion, safe use, and appropriate storage and disposal of controlled substances**; the appropriate use of the Vermont Prescription Monitoring System; risk assessment for abuse or addiction; pharmacological and nonpharmacological alternatives to opioids for managing pain; medication tapering; and relevant State and**

federal laws and regulations concerning the prescription of opioid controlled substances (VDH).

(b) The Department of Health shall consult with the Board of Veterinary Medicine to develop recommendations regarding appropriate use of the Vermont Prescription Monitoring System by veterinarians regarding drugs prescribed for animals and dispensed to their owners, as well as appropriate continuing education for veterinarians in the topics described in subsection (a) of this section. On or before January 15, 2017, the Department shall report its findings and recommendations to the House Committees on Agriculture and on Human Services and the Senate Committees on Agriculture and on Health and Welfare.

* * * Medical Education Core Competencies * * *

Sec. 10. MEDICAL EDUCATION CORE COMPENTENCIES; PREVENTION AND MANAGEMENT OF PRESCRIPTION DRUG MISUSE

The Commissioner of Health shall collaborate with the Dean of the University of Vermont College of Medicine to develop appropriate curricular interventions and innovations to ensure that medical students receive certain core competencies related to safe prescribing practices and to screening, prevention, and intervention for cases of prescription drug misuse and abuse. The goal of the core competencies shall be to support future physicians over

the course of their medical education to develop skills and a foundational knowledge in the prevention of prescription drug misuse. These competencies should be clear baseline standards for preventing prescription drug misuse, treating patients at risk for substance use disorders, and managing substance use disorders as a chronic disease, as well as developing knowledge in the areas of screening, evaluation, treatment planning, and supportive recovery.

* * * Community Grant Program for Opioid Prevention * * *

Sec. 11. REGIONAL PREVENTION PARTNERSHIPS

To the extent funds are available, the Department of Health shall establish a community grant program for the purpose of supporting local opioid prevention strategies. This program shall support evidence-based approaches and shall be based on a comprehensive community plan including community education and initiatives designed to increase awareness or implement local programs, or both. Partnerships involving schools, local government, and hospitals shall receive priority.

* * * Distribution of Naloxone to Emergency Medical Services Personnel * * *

Sec. 12. 33 V.S.A. § 2004 is amended to read:

§ 2004. MANUFACTURER FEE

(a) Annually, each pharmaceutical manufacturer or labeler of prescription drugs that are paid for by the Department of Vermont Health Access for individuals participating in Medicaid, Dr. Dynasaur, or

VPharm shall pay a fee to the Agency of Human Services. The fee shall be 0.5 percent of the previous calendar year's prescription drug spending by the Department and shall be assessed based on manufacturer labeler codes as used in the Medicaid rebate program.

(b) Fees collected under this section shall fund collection and analysis of information on pharmaceutical marketing activities under 18 V.S.A. §§ 4632 and 4633, analysis of prescription drug data needed by the Office of the Attorney General for enforcement activities, the Vermont Prescription Monitoring System established in 18 V.S.A. chapter 84A, the evidence-based education program established in 18 V.S.A. chapter 91, subchapter 2, the purchase and distribution of naloxone to emergency medical services personnel, and any opioid-antagonist education, training, and distribution program operated by the Department of Health or its agents. The fees shall be collected in the Evidence-Based Education and Advertising Fund established in section 2004a of this title.

(c) The Secretary of Human Services or designee shall make rules for the implementation of this section.

Sec. 13. 33 V.S.A. § 2004a(a) is amended to read:

(a) The Evidence-Based Education and Advertising Fund is established in the State Treasury as a special fund to be a source of financing for activities relating to fund collection and analysis of information on pharmaceutical

marketing activities under 18 V.S.A. §§ 4632 and 4633, for analysis of prescription drug data needed by the Office of the Attorney General for enforcement activities, for the Vermont Prescription Monitoring System established in 18 V.S.A. chapter 84A, for the evidence-based education program established in 18 V.S.A. chapter 91, subchapter 2, for the purchase and distribution of naloxone to emergency medical services personnel, and for the support of any opioid-antagonist education, training, and distribution program operated by the Department of Health or its agents. Monies deposited into the Fund shall be used for the purposes described in this section.

* * * Unified Pain Management System Advisory Council * * *

Sec. 14. 2013 Acts and Resolves No. 75, Sec. 14 is amended to read:

Sec. 14. UNIFIED PAIN MANAGEMENT SYSTEM ADVISORY COUNCIL (VDH proposal)

(a) There is hereby created a Unified Pain Management System Advisory Council for the purpose of advising the Commissioner of Health on matters relating to the appropriate use of controlled substances in treating chronic pain and addiction and in preventing prescription drug abuse.

(b) The Unified Pain Management System Advisory Council shall consist of the following members:

* * *

(24) an advanced practice registered nurse full-time faculty member from the University of Vermont's Department of Nursing; ~~and~~

(25) a consumer representative who is either a consumer in recovery from prescription drug abuse or a consumer receiving medical treatment for chronic noncancer-related pain; and

(26) up to three adjunct members appointed by the Commissioner in consultation with the Opiate Prescribing Task Force (VDH).

* * * Acupuncture * * *

Sec. 15. ACUPUNCTURE AS ALTERNATIVE TREATMENT FOR CHRONIC PAIN AND SUBSTANCE USE DISORDER; REPORTS (VDH proposal)

(a) The Director of Health Care Reform in the Agency of Administration, in consultation with the Department of Health and the Department of Human Resources, shall review Vermont State employees' experience with acupuncture for treatment of chronic pain. On or before January 15, 2017, the Director shall report his or her findings to the House Committees on Health Care and on Human Services and the Senate Committee on Health and Welfare.

(b) The Department of Vermont Health Access shall evaluate the evidence supporting the use of acupuncture as a modality for treating and managing chronic pain in Medicaid beneficiaries. On or before January

15, 2017, the Department shall report to the House Committees on Health Care and on Human Services and the Senate Committee on Health and Welfare its assessment of whether Vermont's Medicaid program should provide coverage for acupuncture when used to treat or manage chronic pain.

(c) Each nonprofit hospital and medical service corporation licensed to do business in this State and providing coverage for chronic pain shall evaluate the evidence supporting the use of acupuncture as a modality for treating and managing chronic pain in its enrollees, including the experience of other states in which acupuncture is covered by health insurance plans. On or before January 15, 2017, each such corporation shall report to the House Committees on Health Care and on Human Services and the Senate Committee on Health and Welfare its assessment of whether its insurance plans should provide coverage for acupuncture when used to treat or manage chronic pain.

(d) On or before January 15, 2017, the Department of Health, Division of Alcohol and Drug Abuse Programs shall make available to its preferred provider network evidence-based best practices related to the use of acupuncture to treat substance use disorder.

* * * Rulemaking * * *

Sec. 16. PRESCRIBING OPIOIDS FOR ACUTE AND CHRONIC PAIN; RULEMAKING

The Commissioner of Health shall adopt rules governing the prescription of opioids for acute pain and chronic pain and for the use of the Vermont Prescription Monitoring System. The rules ~~**shall**~~ **may** include numeric and temporal limitations on the number of pills prescribed, including a maximum ~~**of 10**~~ **number of** pills **to be prescribed** following minor medical procedures. The rules ~~**shall**~~ **may** require the contemporaneous prescription of naloxone in certain circumstances, and shall require informed consent for patients that explains the risks associated with taking opioids, including addiction, physical dependence, side effects, tolerance, overdose, and death. The rules shall also require prescribers prescribing opioids to patients to provide information concerning the safe storage and disposal of controlled substances.

* * * Appropriation for Naloxone * * *

Sec. 17. APPROPRIATION

The sum of **$32,000.00** is appropriated from the Evidence-Based Education and Advertising Fund to the Department of Health in fiscal year 2017 for the purpose of purchasing and distributing naloxone to emergency medical services personnel throughout the State.

* * * Effective Dates * * *

Sec. 18. EFFECTIVE DATES

(a) Secs. 1 (VPMS), 3 (opioid addiction treatment care coordination), **8 (role of pharmacies; report),** 13 (**funding for** naloxone), and 17 (appropriation) shall take effect on July 1, 2016, except that subdivision (f)(1) (dispenser reporting to VPMS) shall take effect 30 days following notice and a determination by the Commissioner of Health that reporting every 24 hours is practicable.

(b) Secs. 2 (statewide drug disposal program), 4 (telemedicine pilot), 5–7 (clinical pharmacy), 10 (medical education), 11 (regional partnerships), **14 (Unified Pain Management System Advisory Council membership), 15 (acupuncture studies),** 16 (rulemaking), and this section shall take effect on passage, except that the amendments in Sec. 7 to 8 V.S.A. § 4089j(b) (pharmacist reimbursement for pill counts) shall take effect on July 1, 2017 to enable sufficient time for Board of Pharmacy rulemaking.

(d) Sec. 9 (continuing education) shall take effect on July 1, 2016 and shall apply beginning with licensing periods beginning on or after that date.

(e) Notwithstanding 1 V.S.A. § 214, Sec. 12 (naloxone; manufacturer fee) shall take effect on passage and shall apply retroactive to January 1, 2016.

(Committee vote: _____)

_____

Senator _____

FOR THE COMMITTEE